

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038085

FILED VS OCT 24 1960

128

Primary Registration District No. 2000

Registrar's No. 1039A

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Greene</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Greene</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Springfield</i>		Length of stay in 1b <i>7 days</i>	c. CITY OR TOWN <i>Springfield</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Johns Hospital</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>1359 East Pacific</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Grant</i> Last <i>Stephenson</i>			4. DATE OF DEATH Month <i>October</i> Day <i>13</i> Year <i>1960</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>March 10, 1872</i>	9. AGE (last birthday) <i>88</i>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>---</i>	11. BIRTHPLACE (City and state or country) <i>Galena, Kansas</i>	12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>	
13a. FATHER'S NAME <i>Thomas S. Stephenson</i>		13b. MOTHER'S MAIDEN NAME <i>Annie unknown</i>		14. NAME OF HUSBAND OR WIFE <i>Minnie Lee Robinson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>unknown</i>	17. INFORMANT <i>Mrs. Rhona Bechtold, Springfield, Mo.</i> Address <i>359 E. Pacific</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Kidney</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 mos</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from *May 15, 1952* to *October 13, 1960* and last saw her/him alive on *Oct. 13, 1960*  
Death occurred at *6:30 p.* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i> (Degree or title) <i>M.D.</i>	22b. ADDRESS <i>211 Professional Building Springfield, Missouri</i>	22c. DATE SIGNED <i>10.14.60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10/16/1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Hiland Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Oilton, Oklahoma</i>
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24. FUNERAL DIRECTOR <i>J. Dean Harris, Clever, Missouri</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>10-17-60</i>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4390

P. O. Address Cleveland, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.